FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08674

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08674

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Leonardtown~~, Leonardtown
c. LENGTH OF STAY IN 1b: D. O. A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ST. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural — Avenue — 18:1
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marion — Middle: Ray — Last: Bailey

4. DATE OF DEATH: Month: June — Day: 21, — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: July 26, 1902

9. AGE (In years last birthday): 64 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Winfield S. Maddox

14. MOTHER'S MAIDEN NAME: Sadie Viola Curtin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: J. Lewis Bailey — Address: Avenue, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Inter cranial damage — DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) — DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH: immed

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Collision - auto & bus

20c. TIME OF INJURY Month, Day, Year — Hour a.m.: 10 50 — 6-21 19 67

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Rts 234-238

20f. (City or town) (County) (State): Chaptico St Marys Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Wm D Boyd M.D.

EXAMINER'S NAME (Type): William D. Boyd M. D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

22. DATE SIGNED: 6/21/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 24, 1967

23c. NAME OF CEMETERY OR CREMATORY: St. Josephs

23d. LOCATION (City or Town) (County) (State): Morganza, Maryland

24. FUNERAL DIRECTOR — ADDRESS: W. Clarke Mattingley — Leonardtown, Maryland

25a. REC'D BY REGISTRAR — DATE: JUN 26 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08675 08675

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: ST. MARYS — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): LEONARDTOWN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): ST. MARYS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ST. MARYS
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): LEXINGTON PARK
d. STREET ADDRESS: BOX 237
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PAUL KEX Middle EDISON Last BARNES

4. DATE OF DEATH: Month JUNE Day 10 Year 19 67

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/20/1919

9. AGE (In years last birthday): 48 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STOCK CLERK

10b. KIND OF BUSINESS OR INDUSTRY: CIVIL SERVICE

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: J. EUGENE BARNES

14. MOTHER'S MAIDEN NAME: ANNIE C. EDGESTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): YES (If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 214 16 7166

17. INFORMANT Address: MR. VICTOR H. BARNES - LEXINGTON PARK, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of pancreas with metastases
157X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-18, 1967 to 6-10, 1967, that (I) (we) last saw the deceased alive on 6-10 1967, and that death occurred at 12:10 a.m. p.m. from the causes and on the date stated above.

22a. SIGNATURE: J C Roa M.D. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/11/67

22c. PHYSICIAN'S NAME (Type): J. ROA M.D.

22d. ADDRESS: LEXINGTON PARK, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 6/12/67

23c. NAME OF CEMETERY OR CREMATORY: HOLY FACE CEMETERY

23d. LOCATION (City, town or county) (State): GREAT MILLS, MARYLAND

24. FUNERAL DIRECTOR: John M. Welch

ADDRESS: JOHN M. WELCH - LEONARDTOWN, MD.

25a. REC'D BY REGISTRAR DATE: JUN 14 1967

25b. REGISTRAR'S SIGNATURE: [illegible] Judge

VR A15 (4)
15M 4-64

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08676

CERTIFICATE OF DEATH

08676

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Abell 18-1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rodney — Middle: — Last: Dickerson

4. DATE OF DEATH: Month: June — Day: 11, — Year: 1967

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 8, 1962

9. AGE (In years last birthday): 5 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John H. Dickerson

14. MOTHER'S MAIDEN NAME: Mary Louise Trent

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mother — Address: same as # 2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchial Pneumonia
DUE TO
(b): Gastro - enteritis
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
5711

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 5th, 1967, to June 11, 1967 that (I) (we) last saw the deceased alive on June 11 1967, and that death occurred at 7 A.M., from causes and on the date stated above.

22a. SIGNATURE: Charles Greenwell M.D. — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): Charles Greenwell M. D.

22d. ADDRESS: Leonardtown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 6-13-67

23c. NAME OF CEMETERY OR CREMATORY: Sacred Heart Cemetery

23d. LOCATION (City or Town) (County) (State): Bushwood, Maryland

24. FUNERAL DIRECTOR: W. Clarke Mattingley — ADDRESS: Leonardtown, Maryland

25a. REC'D BY REGISTRAR DATE: JUN 14 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #1d Film #0390 6/23/67 pc

08677

CERTIFICATE OF DEATH

08677

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): St. Mary's Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Clements 18-1
d. STREET ADDRESS: Rt. 2 Box 115
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sarah — Middle: Jane — Last: Hebb

4. DATE OF DEATH: Month: June — Day: XX 14 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 11, 1878

9. AGE (In years last birthday): 89 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ? ? ?

14. MOTHER'S MAIDEN NAME: Margaret Lue Ashton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Margaret L. Fenwick same as # 2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchial Pneumonia. — INTERVAL BETWEEN ONSET AND DEATH
491X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Intestinal Virus, Hypertension
DUE TO
(c): Senility

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 6/2/67, 19 56, to June 14, 19 67, that (I) (we) last saw the deceased alive on June 14 19 67, and that death occurred at 3 P. M, from causes ond an the date stated above.

22a. SIGNATURE: Charles Greenwell M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Charles Greenwell M. D.

22d. ADDRESS: Leonardtown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-16-67

23c. NAME OF CEMETERY OR CREMATORY: St. Aloysius

23d. LOCATION (City or Town) (County) (State): Leonardtown, Maryland

24. FUNERAL DIRECTOR — ADDRESS: W. Clarke Mattingley Leonardtown, Maryland

25a. REG'D BY REGISTRAR DATE: JUN 19 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08678

CERTIFICATE OF DEATH

08678

1. PLACE OF DEATH
a. COUNTY: ST. MARY'S — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): LEONARDTOWN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): ST. MARY'S HOSPITAL

2. USUAL RESIDENCE (Where deceosed fived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ST. MARY'S
c. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): LOVEVILLE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First	Middle	Lost	4. DATE OF DEATH Month	Doy	Year
JOSEPH	ARTHUR	HOLT	JUNE	2	1967

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In yeors lost birthday)	IF UNDER 1 YEAR Months	Doys	IF UNDER 24 HRS. Hours	Min.
MALE	COLORED	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	APRIL 25, 1891	76 yrs.				

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & Stote, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FARMER		MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOSEPH ENDRES HOLT	MARY YOUNG

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No		HELEN E. HOLT — SAME AS #2 ABOVE

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO (b): arteriosclerotic HD — 3 yrs
DUE TO (c):
Conditions, if any, which gove rise to immediote couse (o), stoting the underlying couse lost.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20o. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19	20d. INJURY OCCURRED While ot work [ ] Not While ot work [ ]	20e. PLACE OF INJURY (Home, farm, foctory, street, office bldg., etc.)	20f. (City or town) (County) (Stote)

21. **I certify** that (I) (this hospital) attended the deceased from Feb 15, 1966, to June 2, 1967, that (I) (we) last saw the deceased alive an June 1 1967, and that death occurred at 1 P M, from causes and on the date stoted above.

22o. SIGNATURE: William D Boyd M.D. — M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 6-5-67
22c. PHYSICIAN'S NAME (Type): WILLIAM D BOYD, M.D.
22d. ADDRESS: LEONARDTOWN, MARYLAND

23o. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (Stote)
BURIAL	6/5/67	ST. JOSEPH'S	MORGANZA ST. MARY'S MD.

24. FUNERAL DIRECTOR	ADDRESS	25o. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
W. CLARKE MATTINGLEY	LEONARDTOWN, MD.	JUN 6 1967	Charles Judge

4 1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08679 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 08679

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Mechanicsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Mechanicsville 18-1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First George Middle Boyd Last Hunter
4. DATE OF DEATH: Month June Day 16, Year 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]
8. DATE OF BIRTH: Aug. 17, 1899
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Insurance salesman
10b. KIND OF BUSINESS OR INDUSTRY: Insurance
11. BIRTHPLACE (State or foreign country): West Newton, Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David L. Hunter
14. MOTHER'S MAIDEN NAME: Edith B. Markel
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unkown): Yes (If yes give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 214-34-4484
17. INFORMANT: Edwin Slayman Address: Box 88 Kingsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrythmia — INTERVAL BETWEEN ONSET AND DEATH: Unknown
H200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): arteriosclerotic H D — 2 yr
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Wm D Boyd M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
EXAMINER'S NAME (Type): William D. Boyd M. D.
Address (Street, city, town, or county):
22. DATE SIGNED: 6/17/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 20, 1967
23c. NAME OF CEMETERY OR CREMATORY: Millbill Cemetery
23d. LOCATION (City, town or county) (State): South Huntington, Penna.

24. FUNERAL DIRECTOR: C. Richard McCauley
ADDRESS: 901 Linden Ave. West Newton, Pa.
26a. REC'D BY REGISTRAR DATE: JUN 26 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

W. Clarke Mattingly Leonardtown, Md.

VR AI5ME (5)
5M 1/65

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08680

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08680

1. PLACE OF DEATH
a. COUNTY: ST. MARY'S — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ST. MARY'S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN
d. STREET ADDRESS: LAWRENCE AVENUE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY — Middle: MILDRED — Last: KNOTT

4. DATE OF DEATH: Month: JUNE — Day: 2 — Year: 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPT. 20, 1926

9. AGE (In years last birthday): 40 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WAITRESS

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JESSIE CURRIE

14. MOTHER'S MAIDEN NAME: PEARL BROWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 213-22-0296

17. INFORMANT: JOHN A KNOTT — Address: SAME AS #2 ABOVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs
4201
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: Wm D Boyd MD M.D.

EXAMINER'S NAME (Type): WILLIAM D BOYD MD

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 6/2/67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 6/5/'67

23c. NAME OF CEMETERY OR CREMATORY: ST. ALOYSIUS

23d. LOCATION (City or Town) (County) (State): LEONARDTOWN ST. MARY'S MD.

24. FUNERAL DIRECTOR: W. CLARKE MATTINGLEY — ADDRESS: LEONARDTOWN, MD.

25a. REC'D BY REGISTRAR DATE: JUN 5 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08681

CERTIFICATE OF DEATH

08681

1. PLACE OF DEATH
a. COUNTY: St Marys — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): St Marys Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Charles
c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest tawn): Rural-Hughesville 08.2
d. STREET ADDRESS: Rt 1 Box 142
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Mary		Koller	June	26,	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	Cau.	WIDOWED [X]	3-18-1886	81 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework	Domestic	Austria	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	217-36-5339	Willie Koller, Hughesville, Md. Rt 1 Box 142

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vescular Accident — INTERVAL BETWEEN ONSET AND DEATH: 3 mos
331X
DUE TO (b): Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factary, street, affice bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb 26, 1963, to 6/26, 1967, that (I) (we) last saw the deceased alive on 6/26 1967, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: Leon Berube — M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22b. DATE SIGNED: 6-27-67

22c. PHYSICIAN'S NAME (Type): Leon Berube — 22d. ADDRESS: Mechanicsville, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Tawn) (County) (State)
Burial	6-28-67	St Marys Cemetery	Bryantown, Charles, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
The Huntt Funeral Home, Waldorf, Md.	JUN 29 1967	J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08682 08682

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: St. Mary's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b: 73 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission).
a. STATE: Maryland
b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Dameron
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Helene Middle: Elvira Last: Linder

4. DATE OF DEATH: Month: June Day: 15 Year: 1967

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6/6/1873
9. AGE (In Years last birthday): 93 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Sweden
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lars Frederick Hjelm
14. MOTHER'S MAIDEN NAME: Wilhelmina Lebertau

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: James E. Shea Dameron, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Circulatory Collapse — INTERVAL BETWEEN ONSET AND DEATH: hours
DUE TO (b): Aspiration of Vomitus — min
DUE TO (c): Debilitation of Senility — mos
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
794X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/2, 1967 to 6/15, 1967, that (I) (we) last saw the deceased alive on 6/15 1967, and that death occurred at 7:10 A.M., from causes and on the date stated above.

22a. SIGNATURE: J. Patrick Jarboe M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/15/67
22c. PHYSICIAN'S NAME (Type): J. Patrick Jarboe M.D.
22d. ADDRESS: Great Mills, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: June 16, 1967
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
23d. LOCATION (City or Town) (County) (State): Suitland, Maryland

24. FUNERAL DIRECTOR: W. Clarke Mattingley
ADDRESS: Leonardtown, Maryland
25a. REC'D BY REGISTRAR DATE: JUN 19 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08683

CERTIFICATE OF DEATH

08683

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Maddox
c. LENGTH OF STAY IN 1b: 20 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Maddox 181
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Boyd — Middle: Walter — Last: Mayhew

4. DATE OF DEATH: Month: June — Day: 24, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: March 24, 1898

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales man

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Edwin Mayhew

14. MOTHER'S MAIDEN NAME: Minnie Harrison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes

16. SOCIAL SECURITY NO.: 213-10-7449

17. INFORMANT — Address: Catherine V. Mayhew Maddox, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
DUE TO (b): Arteriosclerotic Heart Disease — 15 yr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

H201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19___, to _____, 19___, that (I) (we) last saw the deceased alive on _____, 19___, and that death occurred at _____ M, from causes and on the date stated above.

22a. SIGNATURE: John F. Fenwick M.D. — ATTENDING PHYS. ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 6-26-67

22c. PHYSICIAN'S NAME (Type): John F. Fenwick M. D.

22d. ADDRESS: Leonardtown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 26, 1967

23c. NAME OF CEMETERY OR CREMATORY: Christ Church Cemetery

23d. LOCATION (City or Town) (County) (State): Chaptico, Maryland

24. FUNERAL DIRECTOR — ADDRESS: W. Clarke Mattingley Leonardtown, Maryland

25a. RECD BY REGISTRAR — DATE: JUN 27 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08684

CERTIFICATE OF DEATH

08684

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b: D. O. A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): St. Mary's Hospital

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission)
a. STATE: Maryland
b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give neoresf town): Rural Leonardtown 18-1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary; Middle: Magdalene; Lost: Morgan
4. DATE OF DEATH: Month: June; Day: 19; Year: 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 21, 1889
9. AGE (In yeors last birthdoy): 77 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & Stote, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James H. Jones
14. MOTHER'S MAIDEN NAME: Lucy Spaulding
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Louis C. Morgan Leonardtown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c))
PART I. DEATH WAS CAUSED BY:
4500
IMMEDIATE CAUSE (o): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 10 mo
DUE TO (b): Generalized enteriosclerosis — 4 yrs
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o): Pernicious Anemia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, foctory, street, office bldg., etc.)
20f. (City or town) (County) (Stote)

21. I certify that (I) (this hospital) attended the deceased from _____, 19 63, to June, 19 67, that (I) (we) last saw the deceased alive on 12 June 19 67, and that death occurred at _____ M, from causes and on the date stated above.

22o. SIGNATURE: Leon W Berbue
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type) Leon W. Berbue M. D.
22d. ADDRESS: Mechanicsville, Maryland

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 21, 1967
23c. NAME OF CEMETERY OR CREMATORY: St. Aloysius
23d. LOCATION (City or Town) (County) (Stote): Leonardtown, Maryland

24. FUNERAL DIRECTOR ADDRESS: W. Clarke Mattingley Leonardtown, Maryland
25o. REC'D BY REGISTRAR DATE: JUN 26 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

1 2

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08685

CERTIFICATE OF DEATH

08685

1. PLACE OF DEATH
a. COUNTY: ST. MARY'S
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL HOLLYWOOD
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ST. MARY'S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL HOLLYWOOD,
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First BERNARDINE Middle R. Last RALEY

4. DATE OF DEATH: Month JUNE Day 28, Year 1967

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED [XX] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: OCT. 31, 1882
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (County & State, or foreign country): HOLLYWOOD, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: STEPHEN E. RUSSELL
14. MOTHER'S MAIDEN NAME: ALICE CECIL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 217-36-6639
17. INFORMANT: LAWRENCE Y. RALEY Address: HOLLYWOOD, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Cardio Vascular Disease
DUE TO (c): Cerebral Hemorrhage
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4222

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/16, 1964, to 6/28, 1967, that (I) (we) last saw the deceased alive on 6/28 1967, and that death occurred at 6A M, from causes and on the date stated above.

22a. SIGNATURE: Charles Greenwell M.D. ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): CHARLES GREENWELL M. D.
22d. ADDRESS: LEONARDTOWN, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: JUNE 30, 1967
23c. NAME OF CEMETERY OR CREMATORY: ST. JOHNS CEMETERY
23d. LOCATION (City or Town) (County) (State): HOLLYWOOD, MARYLAND

24. FUNERAL DIRECTOR: W. CLARKE MATTINGLEY ADDRESS: LEONARDTOWN, MARYLAND
25a. REC'D BY REGISTRAR DATE: JUL 10 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08686 08686

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: St. Mary's — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Chaptico
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): State Route 234 & 238

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Prince George
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Camp Springs
   d. STREET ADDRESS: 5201 Middleton Lane
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rose — Middle: Catherine — Last: Reed

4. DATE OF DEATH: Month: June — Day: 21, — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 11, 1900

9. AGE (In years last birthday): 66 yrs.
   IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Peoples Life Ins

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James S. Knott

14. MOTHER'S MAIDEN NAME: Ann Laura Bailey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Laura E. Cuticello — Address: same as # 2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Laceration of Spinal Cord — INTERVAL BETWEEN ONSET AND DEATH: instant

Conditions, if any, which gave rise to immediate cause (a), steting the underlying cause last.
DUE TO (b): Fracture cervical vert. — "
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): collision auto + bus

20c. TIME OF INJURY Month, Day, Year: Hour e.m. 10:50 p.m. — 6-11-67

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Rts 234-238

20f. (City or town): Chaptico (County): St Mary (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: William D. Boyd M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): William D. Boyd M. D.

Address (Street, city, town, or county):

22. DATE SIGNED: 6/21/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-24-1967

23c. NAME OF CEMETERY OR CREMATORY: Resurrection

23d. LOCATION (City, town or county): Clinton, Prince George, Md (State):

24. FUNERAL DIRECTOR — ADDRESS: Mattingley Funeral Home Leonardtown, Md.

25a. REC'D BY REGISTRAR DATE: JUN 23 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR AISME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08687 08687

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: St. Mary's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Scotland
c. LENGTH OF STAY IN 1b: 26 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Scotland
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Janie; Middle: Fish; Last: Saunders

4. DATE OF DEATH: Month: June; Day: 30; Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Feb. 20, 1890
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alfred G. Sanner
14. MOTHER'S MAIDEN NAME: Alice Fish

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 218-38-5495
17. INFORMANT: A.E. Vernon Saunders Address: Valley Lee, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: min
DUE TO
(b): Myocardial Infarction — min
DUE TO
(c): Coronary Artery Disease — yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from _____, 1967, to 6/30, 1967 that (I) (~~we~~) last saw the deceased alive on 6/30 1967, and that death occurred at 12 M. from causes and on the date stated above.

22a. SIGNATURE: [signature]
M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 6/30/67
22c. PHYSICIAN'S NAME (Type): James P. Jarboe M. D.
22d. ADDRESS: Great Mills, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: July 2, 1967
23c. NAME OF CEMETERY OR CREMATORY: Friendship Cemetery
23d. LOCATION (City or Town) (County) (State): Ridge, St. Mary's, Md.

24. FUNERAL DIRECTOR: W. Clarke Mattingley ADDRESS: Leonardtown, Maryland
25a. REC'D BY REGISTRAR DATE: JUL 10 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08688

CERTIFICATE OF DEATH

08688

1. PLACE OF DEATH
a. COUNTY: St. Mary's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN,
c. LENGTH OF STAY IN 1b: 6 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): AVENUE,
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First JOHN Middle FRANCIS Last THOMPSON

4. DATE OF DEATH: Month JUNE Day 9, Year 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: JAN. 14, 1870

9. AGE (In years last birthday): 97 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMING

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES ALEXANDER THOMPSON

14. MOTHER'S MAIDEN NAME: HARRIET MARIA RALEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 217-36-6878A

17. INFORMANT: MRS PAUL MATTINGLY Address: LEONARDTOWN, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure + Pneumonia — Interval between onset and death: 2 wks.
DUE TO (b): Arteriosclerotic Heart Disease — 20 yr.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19___, to _____, 19___, that (I) (we) last saw the deceased alive on _____ 19___, and that death occurred at _____ M, from causes and on the date stated above.

22a. SIGNATURE: [signature]
M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 6-12-67

22c. PHYSICIAN'S NAME (Type): JOHN F. FENWICK M. D.

22d. ADDRESS: LEONARDTOWN, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: JUNE 12, 1967

23c. NAME OF CEMETERY OR CREMATORY: SACRED HEART CEMETERY

23d. LOCATION (City or Town) (County) (State): BUSHWOOD, MARYLAND

24. FUNERAL DIRECTOR: W. CLARKE MATTINGLEY ADDRESS: LEONARDTOWN, MARYLAND

25a. REC'D BY REGISTRAR DATE: JUN 14 1967

25b. REGISTRAR'S SIGNATURE: [signature]

1-15

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MB. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08683 08689

1. **PLACE OF DEATH**
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b: 1 hour
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): St. Mary's Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Maddox
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: William — Middle: Stanton — Last: Weaver

4. **DATE OF DEATH**: Month: June — Day: 11, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 31, 1922

9. AGE (In years last birthday): 45 yrs.

IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: National Guard

11. BIRTHPLACE (State or foreign country): Madison, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Cleveland L. Weaver

14. MOTHER'S MAIDEN NAME: Mary Saunders

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WWII

16. SOCIAL SECURITY NO.: 223 28 1100

17. **INFORMANT** Address: Geraldine E. Weaver Maddox, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 4201 Coronary occlusion
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 30 min

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Wm D Boyd M.D.

EXAMINER'S NAME (Type): William D. Boyd M. D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 6/12/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/15/67

23c. NAME OF CEMETERY OR CREMATORY: Sacred Heart Cemetery

23d. LOCATION (City or Town) (County) (State): Bushwood, Maryland

24. FUNERAL DIRECTOR — ADDRESS: W. Clarke Mattingley Leonardtown, Maryland

25a. REC'D BY REGISTRAR DATE: JUN 14 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08690 08690

1. PLACE OF DEATH
a. COUNTY: ST. MARYS — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ST. MARYS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ST. MARYS
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - CALIFORNIA
d. STREET ADDRESS: 259 STAR RT.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MINNIE Middle: N/M Last: WIEBER

4. DATE OF DEATH: Month: JUNE Day: 3 Year: 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8/30/1887

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: DOMESTIC

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: FREDERICK WEBER

14. MOTHER'S MAIDEN NAME: ELISE REINECHE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 213 05 3078D

17. INFORMANT: MRS. ELSIE J. TEER Address: SAME AS # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cirrhosis of Liver — INTERVAL BETWEEN ONSET AND DEATH: 1 year
581.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertension and Heart failure.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-27-67 19__, to 6-3-67 19__, that (I) ~~(we)~~ last saw the deceased alive on 6-3-67 19__, and that death occurred at 1A M, from the causes and on the date stated above.

22a. SIGNATURE: W. H. Patrick M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/3/67

22c. PHYSICIAN'S NAME (Type): W. H. PATRICK M.D.

22d. ADDRESS: LEXINGTON PARK, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 6/5/67

23c. NAME OF CEMETERY OR CREMATORY: OAK LAWN CEMETERY

23d. LOCATION (City, town or county) (State): BALTO. CO. MARYLAND

24. FUNERAL DIRECTOR: John M. Welch — ADDRESS: JOHN M. WELCH - LEONARDTOWN, MD.

25a. REC'D BY REGISTRAR DATE: JUN 7 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64